Frederick County Health Access Program

An Initiative of the Frederick County Health Care Coalition
In Partnership with the Frederick County Health Department
Providing Connections to Care
Ph. 301-788-8592 FAX 866-430-9751
www.co.frederick.md.us/healthaccess

This is an application for the Frederick County Health Access Program which helps uninsured Frederick County residents, children and adults, access health care services for a low per-visit fee. Limited labs and diagnostic tests will be paid for by the program. Enrollees will be assisted with applying for prescription and hospital assistance as needed. Residents must meet income qualifications and not be eligible for any other health insurance program. Once enrolled, participants must reapply every six months.

In order to apply, you must:

1. **Complete the application and sign the release of information form.**

2. **Provide proof of all current income. Provide a copy of at least ONE of the following:**

   - Pay stub(s) for a recent period of four weeks; must be consecutive pay periods
   - Employer's letter stating current income
   - If self employed, most current signed and dated Federal Income Tax Return, including profit/loss tax form
   - Most recent Personal and Business Federal Income Tax Return

   If received, must also provide a copy of award letters for Social Security, SSD, SSI, or Unemployment Benefits.

3. **Provide proof of current residency in Frederick County.**
   Provide copy of one of the following:

   - Driver's License or other identification card with name and current address (voter's card, MVA, etc.)
   - Lease/mortgage with name and current address
   - Utility bill with name and current address of applicant (not a cell phone bill)

4. **Social Security Card for each applicant who has a Social Security number**

If you have any questions, please contact the Program Coordinator at 301-788-8592.

If you are eligible for this program and enrolled, you will be expected to sign a Patient Responsibility Agreement and Confidentiality Form (HIPPA) and will be given further instructions regarding your participation.

FREDERICK COUNTY HEALTH ACCESS PROGRAM –
ENROLLMENT APPLICATION

APPLIC/ID#_____
DATE COMPL._____
Referred by:_____

Head of Household:
Last Name _____ First Name_____Middle Init._____
Married? ____Yes ____No Pregnant? ____Yes ____No Prenatal Care?_____
Address_____Apt. #_____
City_____State_____ ZipCode_____
Home Phone _____Cell_____Work_____
Mailing Address (if different from above)_____
Email(s) _____
How long at current address?_____ Proof of county residency? _____

Are you or anyone applying for FCHAP covered by any type of health insurance? _____Yes _____No
Have you applied for public insurance programs (Medical Assistance, Medicaid, PAC, MCHIP)?_____
If so, when? _____
Do you currently have any unpaid medical bills/approximately how much?_____
(For informational purposes only – this program cannot pay your medical debt)

Household: Please list everyone in your household (including yourself)

Name:	**Social Sec.# (if available)**	**Relationship**	**Date of Birth**	**Sex**	**Race**	**Enrolled in MCHIP?**	**Applying for this person?**
_____	_____	_____	_____	___	_____	yes no	yes no
_____	_____	_____	_____	___	_____	yes no	yes no
_____	_____	_____	_____	___	_____	yes no	yes no
_____	_____	_____	_____	___	_____	yes no	yes no
_____	_____	_____	_____	___	_____	yes no	yes no

Income Information:

List any employer wages, earning, or money from a job or money from a self-employment that you, your spouse, or others listed above receive **(attach copy of income documentation)**

Name of Person Employed	**Employer**	**Employer Address**	**Phone**	**Salary**	**Paid how often**	**Begin Date**
_____	_____	_____		_____	_____	_____
_____	_____	_____		_____	_____	_____
_____	_____	_____		_____	_____	_____

Is health insurance available through any of these employers? _____

Other Financial Resources:

List any alimony, child support, pension, social security, rental income, retirement, strike benefits, unemployment, veteran's, worker's compensation benefits that you or your household may receive **(attach copy of income documentation)**

Person Receiving Benefit	**Type of Benefit**	**Amount Rec'd**	**How Often?**
_____	_____	_____	_____
_____	_____	_____	_____

APPLIC/ID#_____

ADDITIONAL INFORMATION (To be completed for each applicant)

Last Name_____ First Name_____MI_____ Date of Birth_____
Primary Language_____ Speak English? ____Yes ____ No

Is there a particular place that you usually go when you are sick or need advice about your health? (such as a private doctor, clinic, Mission of Mercy, the hospital emergency room)Please name: _____
When was your last visit?_____
How long has it been since you last visited a doctor for a routine check-up? (A routine check-up is a general physical exam, not for a specific injury, illness or condition.)

<1 yr >1 less than 2yrs. >2 less than 5 yrs. >5 yrs Never

In the past year, was there a time when you needed to see a doctor but could not because of the cost? Yes No

Was there a time when you were ordered labs or medical tests but didn't get them because of the cost? Yes No

Was there a time when you were advised to see a specialist but could not because of the cost? Yes No

Was there a time when you needed a prescribed medicine but didn't get it because you couldn't afford it? Yes No

Did you ever skip or take less medicine than ordered to make it last longer and save money? Yes No

Visits to the hospital emergency department in the past 12 months? (please check total number)

____0 _____1 ____2 _____3 _____4 _____5 or more

Please list reasons for visits:_____

When was the last time you visited a dentist or dental clinic?_____
When was the last time you had an eye exam in which the pupils were dilated (using eye drops that would have made the eyes temporarily sensitive to light)? _____

CURRENT HEALTH STATUS
Known medical conditions (ongoing/chronic)_____

_____
Current Medications/Prescribed By Whom?

_____

_____

How would you describe your general health?

1	2	3	4	5
Poor	Fair	Good	Very Good	Excellent

HEALTH GOALS:

_____

_____